City of Memphis Retiree CHANGE FORM

NOTE: Complete ONLY if you are changing or canceling existing health coverage

RETIREE INFORMATION

Retiree Name (Last Name, First Name, Middle Initial)

List PCP ID Number

Social Security Number --- ---

Sex (M or F)

Date of Birth – MM/DD/YY

Street Address

City **State** **Zip**

Daytime Phone Number ( ) -

Evening Phone Number ( ) -

Division

E-Mail Address

ENROLLED IN (Complete all that applies)

☐ MEDICARE ☐ NON-MEDICARE

☐ CITY OF MEMPHIS BASIC

☐ CITY OF MEMPHIS PREMIER

☐ Enroll ☐ Delete ☐ CANCEL

☐ Waive Coverage NO CHANGES

YOUR PLAN WILL COVER

☐ FAMILY ☐ SINGLE

EMPLOYER USE ONLY

ENROLLMENT DATE RETIREE / /

ENROLLMENT DATE DEPENDENT / /

TERMINATION DATE / /

DIVISION CODE

ENTERED BY:

HIRE DATE: / /

STATUS ___RETIREE ___SURVIVOR

List all dependents you wish to____ ADD TO YOUR COVERAGE or ____DELETE FROM YOUR COVERAGE or _____ UPDATE SOCIAL SECURITY NUMBER on your coverage

Last Name	First Name	Initial	Social Security #	Date of Birth (MM/DD/YY)	Sex (M or F)	Full Time Student (YES / NO)	For Premier ONLY (List PCP ID Number)
Spouse							
Dependent							
Dependent							
Dependent							
Dependent							

If you or your dependents are covered by other group insurance, please fill out the following information:

Name of Person covered by other insurance

Social Security Number

Medicare ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Part D

Effective Date / /

Name of Company this Person works for

Group No.

List those covered under Medicare
Name: **Relationship:**

Name of other Insurance Company

Effective Date:

Comments:

List dependents Covered:

By signing below, I certify that: the information provided above is true and correct. I accept the plan rules as set forth by the City of Memphis; and I authorize payroll deduction for the plan above

Form must be completed and signed by City retiree to be accepted.	REC'D BY / DATE	NOTARY SIGNATURE	NOTARY EXP. DATE

Retiree's Signature	Date			